PATIENT RECORDS ACCESS REQUEST FORM

The Birth Center: Holistic Women's Health Care LLC

620 Churchmans Road, Suite 101, Newark, DE 19702
Phone: 302-658-2229 Fax: 302-658-2382

I hereby authorize The Birth Center to disclose the following information:

_____ Full medical records held by The Birth Center

_____ Medical Records for the period _____ through _____

_____ A specific portion/section of the record as follows:

_____

_____

From the Medical Records of:

Name: _____

Date of Birth: _____

For the purpose of:

_____

_____

To the office of:
Name: _____

Phone: _____ Fax: _____

I understand that unless earlier revoked, this request/authorization expires on _____/_____/_____ or upon receipt of the above requested records by the Birth Center. I may revoke this request/authorization in writing any time prior to the expiration date or transmission of records. I also understand that information from the transmitted records may be re-disclosed in the treatment or billing of my medical condition.

_____ _____

Signature: Date:

_____ _____

Print Name Relationship to Patient